The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage including your plan's Plan document, visit www.deltahealthsystems.com or call 1-800-291-0726. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.deltahealthsystems.com or www.cciio.cms.gov or call 1-800-291-0726 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network Provider per plan year: $500/individual; $1,500/family. Non-network Provider per plan year: $1,500/individual; $3,000/family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family member on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care performed by in-network providers, and outpatient prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network Provider: $5,000/individual; $10,000/family per plan year. The out-of-pocket limit on outpatient drugs per plan year is $1,600/individual; $3,200/family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family member in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, health care this plan doesn't cover, outpatient retail/mail order drug expenses (which have a separate out-of-pocket limit), and out-of-network deductibles, copayments and coinsurance except an emergency room visit in cases of an emergency.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.anthem.com/ca or call 1-800-274-7767 for a list of participating in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance.	50% coinsurance.	None
	Specialist visit	20% coinsurance.	50% coinsurance.	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	50% coinsurance.	Plan covers preventive services and supplies required by the Health Reform law. Details at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/. Age and frequency guidelines apply to covered preventive care. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance.	50% coinsurance.	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance.	50% coinsurance.	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or call 1-888-895-2557.	Generic drugs	Retail Pharmacy for 30-day supply: $10 copayment/prescription; Mail Order for 90-day supply: $20 copayment/prescription. Deductible does not apply. No charge for FDA-approved generic contraceptives.	Not covered.	• You pay the lesser of the copayment or the drug cost. • Some prescriptions are subject to preauthorization to avoid non-payment. • Certain over-the-counter (OTC) drugs are payable at no charge with a prescription, in compliance with Health Reform. • Mail Order is required for maintenance medications after the first fill at a retail pharmacy.
	Preferred brand drugs	Retail Pharmacy for 30-day supply: $35 copayment/prescription; Mail Order for 90-day supply: $70 copayment/prescription. Deductible does not apply. No charge for FDA-approved brand name contraceptives if a generic is medically inappropriate.	Not covered.	
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: 50% coinsurance. Mail Order for 90-day supply: 50% coinsurance. Deductible does not apply.	Not covered.	
	Specialty drugs	Up to a 30-day supply, you pay the same amount as listed under Retail Pharmacy in the rows above. Deductible does not apply.	Not covered.	Specialty drugs require preauthorization (to avoid non-payment) by calling Caremark at 1-866-387-2573.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance.	50% coinsurance.	Preauthorization of outpatient surgery is required to avoid non-payment of expenses.
	Physician/surgeon fees	20% coinsurance.	50% coinsurance.	Preauthorization of outpatient surgery is required to avoid non-payment of expenses.
If you need immediate medical attention	Emergency room care	20% coinsurance.	20% coinsurance.	Coinsurance increases to 50% if ER was used in a non-emergency situation. Physician/provider's professional fees may be billed separately.
	Emergency medical transportation	20% coinsurance.	50% coinsurance.	None
	Urgent care	20% coinsurance.	50% coinsurance.	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$75 copayment per admission plus you pay 20% coinsurance.	$200 copayment per admission plus you pay 20% coinsurance.	Preauthorization of elective hospital admission is required to avoid non-payment of expenses. Private room is covered only if medically necessary or the hospital only has private rooms.
	Physician/surgeon fees	20% coinsurance.	50% coinsurance.	Preauthorization of elective hospital admission is required to avoid non-payment of expenses.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance.	50% coinsurance.	Plan covers up to three EAP visits (at no charge) through Integrated Behavioral Health at (800) 395-1616.
	Inpatient services	$75 copayment per admission plus you pay 20% coinsurance.	$200 copayment per admission plus you pay 20% coinsurance.	Preauthorization of elective admission is required to avoid non-payment of expenses.
If you are pregnant	Office visits	20% coinsurance.	50% coinsurance.	• Cost sharing does not apply for preventive services. • Depending on the type of services, a copayment, coinsurance or deductible may apply. • Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). • Prenatal care (other than ACA-required preventive screening is **not covered** for dependent children. Delivery expenses are **not covered** for dependent children. • Preauthorization is required to avoid non-payment of expenses only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section.
	Childbirth delivery professional services	20% coinsurance.	50% coinsurance.	
	Childbirth delivery facility services	$75 copayment per admission plus you pay 20% coinsurance.	$200 copayment per admission plus you pay 50% coinsurance.	
If you need help recovering or have other special health needs	Home health care	20% coinsurance.	Not covered.	None
	Rehabilitation services	20% coinsurance.	50% coinsurance.	Preauthorization of outpatient physical, occupational and speech therapy is required to avoid non-payment of expenses.
	Habilitation services	20% coinsurance.	50% coinsurance.	Covered for speech therapy. Preauthorization of speech therapy is required to avoid non-payment of expenses.
	Skilled nursing care	$75 copayment per admission plus you pay 20% coinsurance.	$200 copayment per admission plus you pay 50% coinsurance.	Payable only if transferred directly from a covered inpatient stay.
	Durable medical equipment	20% coinsurance.	50% coinsurance.	No charge from in-network providers for breastfeeding pump & supplies needed to operate the pump.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	20% coinsurance.	Not covered.	Preauthorization of hospice is required to avoid non-payment of expenses.
If your child needs dental or eye care	Children's eye exam	Your cost depends on the separate vision plan you select.	Not covered.	If you elect vision coverage, it will be available under a separate vision plan.
	Children's glasses	Your cost depends on the separate vision plan you select.	Not covered.	If you elect vision coverage, it will be available under a separate vision plan.
	Children's dental check-up	Your cost depends on the separate dental plan you select.	Not covered.	If you elect dental coverage, it will be available under a separate dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs (except as required by health reform law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery (when necessary due to life-threatening conditions resulting from morbid obesity)
- Chiropractic care
- Dental care (Adult) (Child) if you elect the separate Dental plan
- Infertility treatment (includes physician services, diagnostic tests, medication, surgery, and gamete intrafallopian transfer)
- Routine eye care (Adult) (Child) and eyeglasses if you elect the separate Vision plan
- Routine foot care (payable when treating diabetic or peripheral vascular insufficiency affecting the feet)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Medical Plan Claims Administrator **Delta Health Systems or call 1-800-291-0726**. Additionally, a consumer assistance program can help you file your appeal. Contact (888) 466-2219 in California. This website lists states with a Consumer Assistance Program: https://www.cms.gov/cciio/resources/consumer-assistance-grants/.

Does this plan provide Minimum Essential Coverage? **Yes.** If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes.** If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-291-0726.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-291-0726.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-291-0726.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) copayment & coinsurance** **$75 copayment +20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost sharing	
Deductibles	$500
Copayments	$260
Coinsurance	$1,830
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,600**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) copayment & coinsurance** **$75 copayment + 20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost sharing	
Deductibles	$500
Copayments	$1,070
Coinsurance	$120
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,750**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$290
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$790**

Keep in mind that this medical Plan includes a Health Reimbursement Arrangement (HRA). If you have available funds in your HRA, you may be reimbursed for certain eligible out-of-pocket costs as well as for certain types of medical expenses you incur that may not be covered by the medical Plan.

5477147v1/00479.032 ngf

The **plan** would be responsible for the other costs of these EXAMPLE covered services.